

Applying to become a member of LA Health Medical Scheme (with underwriting) 2025

Contact details

Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

Thank you for deciding to apply to join LA Health Medical Scheme. This document is an application form for membership. It also contains some rules for membership. Please make sure you read and understand the rules.

Who we are

LA Health Medical Scheme (referred to as ‘the Scheme’), registration number 1145, is the medical scheme that you are applying to become a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as ‘the administrator’) is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Read and understand the rules for membership (section 10).
3. Main applicant to sign and date section 6, 9 and 10 and any changes.
4. Email the completed and signed form to application@lahealthms.co.za.
5. Please attach a copy of each applicant’s identity document to this application form. We also accept valid passports and birth certificates for children.
6. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.

Once you send us your application form, here is what will happen:

- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will activate your membership and send you a letter of confirmation when we are not applying any waiting periods or late-joiner penalties or a counter-offer letter, which will indicate any conditions applicable to your membership (waiting periods and/or late-joiner penalties). You may accept the offer by signing and returning this letter for us to activate your membership.
- We will send you the counter offer letter and any outstanding underwriting requirements where we cannot offer standard terms of acceptance for both you and your dependant/s (adult and child dependant/s).
- We will send you a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- Once we have completed the process, we will send you your new member pack via email or SMS.

If you do not hear from us seven days after sending us your application form, please contact us on **0860 100 345** or your LA Health broker.

When you sign this application, you confirm that you have read and understood the terms and conditions (Section 10 of this form) for membership and agree to them.

I consent to my spouse and/or adult dependant acting on my behalf and providing my personal information, including health information, to Discovery Health for the purpose of my application to join LA Health Medical Scheme.

Yes No

1. About yourself (main applicant)

When do you want your cover to start?

Are you in active employment? Are you retired from employment?

Title Initials

Surname

First name(s)

ID or passport number

Gender M F Date of birth

Race African Coloured Indian / Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Preferred communication Email

LHABML001

Telephone (H) Telephone (W)

Cellphone

Email

Please supply a personal email address and not a .gov email address, as your employer's firewall may prevent our emails from reaching you.

Physical address

Unit/Suite number Complex name

Street number Street name

Suburb

City Postal code

Occupation Tax number

2. About your spouse or partner (only complete if applying for cover)

Title Initials

Surname

First name(s)

Previous or maiden name

ID or passport number

Gender M F Date of birth

Race African Coloured Indian / Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Telephone (H) Telephone (W)

Cellphone Tax number

Email

Declaration

If you are not legally married and you cannot give us a marriage certificate, you have to complete the following section in full. If both parties have not signed and dated the below section, we will halt the application process until we receive the section signed and dated by both parties.

We declare we are in a long-term, committed relationship that is like a marriage and that we live together at the same residence. We understand that by signing this declaration, we agree to tell the Scheme about any change to the status of our relationship or any change to our living arrangements, such as separation. We further understand that if the information we give about our relationship or residency is false in any way, the Scheme reserves the right to end both our memberships.

Since when have you and your partner been in this relationship that is like a marriage

Signature of main applicant

Date

Original signature required

Signature of partner

Date

Original signature required

3. About your dependant/s (only complete if applying for cover)

Dependant 1

Title Initials

Surname

First name(s)

ID or passport number

Gender M F Date of birth

Race African Coloured Indian / Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e., adopted child, foster child. Please provide legal proof)

If your dependant is 21 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? R .

If the adult dependant you are applying for is financially dependent on you, please attach bank statements for the latest 3 months and an affidavit from the main member confirming the financial dependency and the reason for joining.

Dependant 2

Title Initials

Surname

First name(s)

ID or passport number

Gender M F Date of birth

Race African Coloured Indian / Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e., adopted child, foster child. Please provide legal proof)

If your dependant is 21 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? R .

If the adult dependant you are applying for is financially dependent on you, please attach bank statements for the latest 3 months and an affidavit from the main member confirming the financial dependency and the reason for joining.

Dependant 3

Title Initials

Surname

First name(s)

ID or passport number

Gender M F Date of birth

Race African Coloured Indian / Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e., adopted child, foster child. Please provide legal proof)

If your dependant is 21 years and older, are they:

Married? Yes No

Financially dependent on you? Yes No

Disabled? Yes No

A student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? R

If the adult dependant you are applying for is financially dependent on you, please attach bank statements for the latest 3 months and an affidavit from the main member confirming the financial dependency and the reason for joining.

4. Please select your benefit option

You have the right to ask for help in selecting a benefit option that suits your needs. By signing this application you confirm that you are familiar with the conditions and benefits of the Option you select.

LA KeyPlus LA Focus LA Comprehensive LA Core LA Active

* All the Benefit Options, except LA KeyPlus, have Medical Savings Accounts. When your LA Health Medical Scheme membership is confirmed, any current Medical Savings Account balance in your previous scheme must be transferred to LA Health Medical Scheme (in terms of the Medical Schemes Act and its regulations).

How would you like us to refund claims from the Medical Savings Account if your Option has one? Scheme Rate Cost

Please complete if you have selected the LA KeyPlus Option:

Main member's income R (total monthly cost to company)

Please complete this if you have selected the LA KeyPlus Option

Table with 4 columns: Name, GP name, Practice number, and rows for Main Applicant, Spouse or partner, and three Dependants.

Your GP must be a LA KeyPlus Network GP so you can have full cover.

Please note: you and your dependant/s can only access day-to-day cover and chronic benefits through the KeyCare Network GPs you chose above.

5. Your employment details

5.1 If your employer is paying your full contribution or a part of it and we need to debit their account, please complete this section

Name of employer, Employee number, Branch name, Employer billing number, Date of employment, Branch code

Please ensure your employer completes this warranty if this application form is not submitted together with an employer application form:

Employer warranty

- 1. We warrant that the main applicant detailed in section 1 is an employee of our organisation
2. The Scheme may bill us for the amount due for this member in the same way as it does for our other employees with the Scheme.

Authorised signatory(ies) Original signature required Names Designations

6. Your banking details

6.1 Your contributions

If you will be paying your contribution in full, please complete this section

Please note: we cannot accept credit card account details.

Bank name	<input type="text"/>											
Branch name	<input type="text"/>						Branch code	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
Account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Type of account	Cheque <input type="checkbox"/>	Savings <input type="checkbox"/>			
Account holder	<input type="text"/>											

Please choose the date you would like us to debit your account: 1st 10th 15th 20th 25th

If your application is captured after the date you chose above, your first debit order will go off on the first of the month and then on the chosen date after that.

Account holder's physical address (own/3rd party/company/trust)

Unit/Suite number	<input type="text"/>	Complex name	<input type="text"/>								
Street number	<input type="text"/>	Street name	<input type="text"/>								
Suburb	<input type="text"/>										
City	<input type="text"/>						Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Account holder contact number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Account holder email address	<input type="text"/>										

As part of the Payment association of South Africa (PASA) debit order mandate requirements you are required to supply the account holder's residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system. If you wish to update any contact details please visit www.lahealth.co.za.

We will debit the account on the date you selected above as your collection date. If the membership is not activated in time for the debit order collection and there is an amount outstanding LA Health will collect that amount in the interim, upon activation.

Can we use this account to refund claims to you? Yes No

If you want to use a different account for claim refunds or if the banking details completed above belong to someone else, please complete section 6.2 to tell us which account to use for claim refunds.

Signature of account holder	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Original signature required

6.2 Your claims refund

If you do not want to use the same banking details for your contribution and claim refunds, please give us the details you would like to use.

Please note: we cannot accept credit card account details

Bank name	<input type="text"/>											
Branch name	<input type="text"/>						Branch code	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
Account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Type of account	Cheque <input type="checkbox"/>	Savings <input type="checkbox"/>			
Account holder	<input type="text"/>											

Account holder's physical address (own/3rd party/company/trust)

Unit/Suite number	<input type="text"/>	Complex name	<input type="text"/>								
Street number	<input type="text"/>	Street name	<input type="text"/>								
Suburb	<input type="text"/>										
City	<input type="text"/>						Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
If third party bank details, please insert the third party ID number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If the third party bank account is a joint account company account trust account , please provide proof of bank account.

Refer to Annexure A of the application form for the proof of bank account required.

Account holder contact number

Account holder email address

As part of the Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holder's residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system. If you wish to update any contact details please visit www.lahealth.co.za.

By signing below, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded.

You must inform us immediately if any of your banking details change.

Signature of account holder

Date

Original signature required

7. Previous medical scheme details (please give us proof in the form of a membership certificate)

Please give us the details of all registered South African medical schemes that you previously belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both. We may also use the information on the membership certificate to determine if we can apply waiting periods.

Main applicant

Name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	

If all dependant/s were on the same medical schemes as completed above, please tick here to confirm this.

If any of your dependant/s applying for cover belonged to different medical schemes, please complete this section

Dependant name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	

8. Your health questions

Have you or **any dependant/s** in this application **ever** experienced, been treated for, or are you currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.

We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customised information relevant to your health status, to develop disease management programmes for specific conditions, to review and enhance Scheme benefits, to improve the Scheme's financial modeling and to assist the Scheme to better assess and mitigate its risk. A condition specific waiting period will only be imposed on your membership if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment within a 12-month period ending on the date on which this application is considered to be fully and properly made.

Please take note that if you have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 8.18 below.

LHABML001

Indication of existing medical conditions on this application does not automatically enroll you/your dependants onto the Scheme's Disease Management programme. If you want to access cover from the Chronic Illness Benefit, you must apply for it.

You must complete a Chronic Illness Benefit application form with your doctor and submit it for review. If your doctor uses HealthID, your doctor can apply for cover online, provided you give your consent. You need to meet the benefit entry criteria for your condition to be registered on the Chronic Illness Benefit. You or your doctor may need to provide certain test results or extra information to finalise your application. Please ensure that these documents are submitted with your application to avoid any delays in the process.

You can find the application form on the website at www.lahealth.co.za.

8.1 Tumours, growths and disorders of the skin

Yes No

Example: abnormal Pap smear results, skin lesions, eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen) result, abscess, any autoimmune conditions, any congenital conditions or other skin conditions

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.2 Heart and circulation conditions

Yes No

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, peripheral vascular disease, any congenital conditions, deep vein thrombosis, pulmonary embolus, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.3 Gynaecological and obstetric conditions

Yes No

Example: abnormal Pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, missed periods, ovarian cyst, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.4 Are you or any of your dependants pregnant or undergoing treatment/investigation for pregnancy?

Yes No

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.5 Mental healthYes No

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (i.e. narcolepsy), eating disorders, Alzheimer's disease, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, Post Traumatic Stress Disorders, counselling, any autoimmune conditions, any congenital conditions and any other psychological conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.6 Metabolic or endocrine conditionsYes No

Example: diabetes mellitus (high blood sugar), diabetes insipidus, thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, metabolic disorders, Conn's syndrome, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.7. Abdominal conditionsYes No

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, ulcerative colitis, Crohn's disease, diverticulitis, Irritable Bowel Syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, ongoing abdominal pain, ascites (fluid in the abdomen) any autoimmune conditions, any congenital conditions, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.8 Brain and nerve conditionsYes No

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain (VP shunt), Intellectual disability, bleeding on the brain, any autoimmune conditions, any congenital conditions, down's syndrome.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.9 Breathing and respiratory conditionsYes No

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia, interstitial lung disease/chronic cough > 3months, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.10 Musculoskeletal (back, bone and muscle pain)Yes No

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, injury, physical disability, prosthesis, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.11 Kidney or urinary conditions including current or past dialysisYes No

Example: kidney failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder, bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.12 Blood conditionsYes No

Example: deep vein thrombosis, anaemia, any autoimmune conditions, any congenital conditions, polycythaemia vera, blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis and other bleeding disorders, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.13 Eye conditionsYes No

Example: cataract, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.14 Ear, nose and throat (ENT) and dentistry conditionsYes No

Example: otitis media (middle ear infection), otitis externa (ear canal infection), hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.15 Male urogenital conditionsYes No

Example: prostate disorders, urogenital defects, varicocele, undescended testes, phimosis, urinary incontinence, retention, any autoimmune conditions, infertility, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.16 Are any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have they been admitted to hospital in the last 12 months?Yes No

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.17 Have any of your dependant/s received medical advice or treatment for symptoms not diagnosed by a medical professional, in the last 12 months before this application?Yes No

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

8.18 Have any of your dependants been diagnosed with or received treatment for, any condition not mentioned in the questions above, in the last 12 months before this application?Yes No

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive you or they must call us on **0860 103 933** within seven working days from the date we activate your LA Health Medical Scheme membership. We treat this information in the strictest confidence. LA Health Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before LA Health Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. We will not indicate the 12-month condition specific waiting period on a counter offer letter, if the waiting period is applied prior to activation of membership due to the sensitivity of this information. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIVCare Programme

9. LA Health Medical Scheme - Privacy Statement

The Scheme refers to LA Health Medical Scheme, registration number 1145, registered with the Council for Medical Schemes.

The Administrator refers to Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider, the administrator and managed care organisation for LA Health Medical Scheme.

We, us, our refer collectively to the Scheme and the Administrator.

You and your refer to you as the employer.

Your employee(s) refer to any person employed by you who applied for membership of LA Health or who is a member of the Scheme

Member(s) refers to your employees and their dependants on the Scheme, which may include their spouse(s), children and other dependants, collectively "their dependants"

Personal information includes information about the members' race, gender, sex, pregnancy, biometrics, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and date of birth of the individual, amongst other things.

Process(ing) (of) information means the lawful and reasonable automated or manual activity of collecting, recording, organising, using, storing, updating, distributing and removing or deleting personal information to ensure that such processing is adequate, relevant and not excessive given the purpose for which it is processed.

Competent person means anyone who is legally competent to consent to any action or decision being taken for any matter concerning a member or dependant, for example a parent, legal guardian or a legal representative appointed by a court to manage the finances, property, or estate of a person unable to do so, because of mental or physical incapacity.

How we will process and disclose members' personal information and communicate with them

1. The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process members' personal information, in a manner that is compliant, ethical, adheres to industry best practice and applicable protection of personal information legislation as enacted from time to time.
2. This Privacy Statement applies to you and the member, if you engage with us physically through our offices, or virtually through our website (www.lahealth.co.za), email, mobile applications such as the Discovery App, social media platforms, over the phone, or otherwise as may be the case from time to time.
3. When you engage with us, you may entrust us with personal information about your employees.
4. We are committed to protecting members' right to privacy. We will keep their personal information confidential. We take protecting your personal information seriously and are continuously developing and updating our security systems, processes and data governance policies.
5. We have a duty to take all reasonably practicable steps to ensure members' personal information is complete, accurate, not misleading and updated on a regular basis. To enable this, we will always endeavour to obtain personal information from members directly. Where we are unable to do so, we will make use of verifiable independent third-party data sources. Thus, members' personal information comprises information they may have given to us or that we may have collected from other sources.
6. Members have the right to object to the processing of their personal information and have a choice whether to accept the Scheme's terms and conditions. However, it is important to note that we require their acceptance to activate and service their medical scheme membership. If they do not accept the terms and conditions, we cannot activate and service their LA Health membership.
7. You and your employees understand and/or acknowledge that when they include their dependants on their application for membership, we will process their personal information for the activation of their membership and to pursue their legitimate interest as a member of the Scheme. By submitting their dependants' relevant personal information, they confirm that they are duly authorised to share such information with us.
8. If an employee is giving consent for a person under 18 (a minor), they confirm that they are the parent or legal guardian of that minor and that they give consent for us to process the minor's personal information for the purposes covered in this Privacy Statement.
9. If an employee shares their personal information with you, or any other third parties, we will not be responsible for how they use this information, nor be responsible for any loss suffered by your employee.
10. You understand and accept that we may process your employees' personal information for the following purposes:
 - 10.1. to verify the accuracy, correctness and completeness of any information provided to us in the course of processing an application for membership, or providing services related to the membership;
 - 10.2. for the administration of the benefits offered by the Option selected;
 - 10.3. for the provision of managed care services to members;
 - 10.4. for the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to the member;
 - 10.5. to profile and analyse risk;
 - 10.6. to share members' personal information with healthcare providers for them to assess or evaluate certain clinical information, when a member is subject to such a clinical assessment;
 - 10.7. to investigate and/or remedy fraud, waste and abuse.
11. By signing the Member Application Form, your employees expressly consent that we can obtain and share information about their creditworthiness, or the creditworthiness of any payer of their contributions with any credit bureau or credit providers' industry association or industry body. This includes information about credit their history, financial history, judgments, default history and sharing of information for purposes of risk analysis, tracing and any related purposes.
12. Examples of when and how we will obtain and share your employees' personal information include:
 - 12.1. Obtaining your employees' personal information from other relevant sources, including medical practitioners, contracted service providers, credit bureaus, entities that are part of Discovery Limited or industry regulatory bodies ("relevant sources") and further processing of such information to consider their membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the relevant sources that their personal information is true, correct and complete;
 - 12.2. Getting from and sharing with you information that is relevant to your employees' applications for membership;

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- 12.3. Communicating with your employees about any changes to their benefits and contributions on the benefit option they have chosen;
- 12.4. Transferring your employees' personal information outside the borders of the Republic of South Africa where appropriate, or if they provide an email address, which is hosted outside the borders of South Africa, or for processing, storage or academic research.
- 12.5. Sharing your employees' personal information to be processed by healthcare providers via a health information exchange to improve members' treatment and healthcare outcomes.
13. If a third party asks us for any of your employees' personal information, we will share it with them only if:
 - 13.1. they have already given their consent for the disclosure of this information to that third party; or
 - 13.2. we have a legal or contractual duty to give the information to that third party.
14. We will provide your employees' personal information to any Discovery Limited entity for the following purposes only:
 - 14.1. to allow for the administration of their profile/membership/benefit option with the entity with whom your employee or their dependant/s already have a relationship; or
 - 14.2. where your employee or their dependant/s have applied for a product, service or benefit from such an entity for the purposes of underwriting.
15. We may process your employees' personal and/or depersonalised information for the following purposes:
 - 15.1. for research and analysis; or
 - 15.2. to support the early identification of medical conditions and/or other lifestyle risks and to encourage your employees to change their lifestyles to lessen the impact of such conditions; or
 - 15.3. to provide personalised advice to your employees about risks to their health, how they may become healthier (such as by seeing a healthcare practitioner, having additional tests done or activating benefits) and the rewards and incentives which they may receive because of undertaking these activities. We will provide this advice to your employees based on market and behavioural research and analysis carried out using their personal, special and or depersonalised information. We may communicate this advice to your employees using the Discovery App or other digital communication channels.
16. Your employees' personal information may be shared with third parties such as academics and researchers, including those outside South Africa. We ensure that the academics and researchers will keep your personal information confidential, and all data will be made anonymous to the extent possible, and where appropriate. No personal information will be made available to an academic or research party unless that party has agreed to abide by strict confidentiality protocols that we require. If we and/or the academic and researcher publish the results of this research, your employees will not be identifiable:
17. By applying for membership, your employees agree that we may transfer their personal information outside South Africa only:
 - 17.1. if they give us an email address that is hosted outside South Africa; or
 - 17.2. to administer certain services, for example, cloud services.
18. When we share your employees' information, we will ensure that, the company, person or regulatory body (in or outside of South Africa) whom we pass their personal information to agrees to treat their information with the same level of protection as we are obliged to.
19. By applying for membership, your employees agree that:
 - 19.1. we may process their information, including personal and special personal information, to adhere to South African legislative reporting obligations and to perform transaction monitoring activities;
 - 19.2. we may communicate such personal information to local regulatory bodies as well as to other relevant governance structure of Discovery Limited, or any of its relevant entities, if any legislative reportable matters are identified.
20. We may process your employees' information using automated means (without human intervention in the decision-making process) to decide about them or their application for any product or service and understand that they may query any decisions made by us.
21. We have the right to use digital / electronic means to communicate with you or your employees about any changes to their benefits or contributions.
22. We have a duty to keep your employees updated about any offers and new products that are made available from time to time. We will send them information of products that suit their needs and that they can afford. For this reason we may obtain data from third parties, such as credit bureaus, to enrich and analyse your employees' personal information. We, any entity of Discovery Limited and/or any contracted third-party service providers may communicate with your employees about these products.
23. Your employees may opt out of receiving marketing information by indicating their preference on www.lahealth.co.za. We will store your personal information to action this request, as soon as reasonably possible.
24. Unless required by law to keep your employees' personal information for a certain period of time or purpose, they agree in their application for membership that we may keep their personal information until they ask us to delete or destroy it. Your employees have the right to ask us to update, correct or delete their personal information, unless the law requires us to keep it. Where we cannot delete their personal information, we will take all practical steps to de-identify it, and for purposes of proof, retain a secure copy of your request.
25. If we become involved in a proposed or actual amalgamation, transfer or merger, acquisition or any form of sale of any assets, as may be appropriate, we have the right to share your employees' personal information with third parties in connection with the transaction. In the case of such an event, the new entity will have access to your employees' personal information.
26. Where we are required by law to collect and keep personal information, we shall do so. At a minimum, this includes the following:
 - 26.1. Legislation applicable to us:
 - Medical Schemes Act, 1998
 - The Consumer Protection Act, 2008
 - The Protection of Personal Information Act, 2013
 - Electronic Communications and Transactions Act, 2002
 - Promotion of Access to Information Act, 2002
 - 26.2. Legislation specific to the Administrator only:
 - Financial Advisory and Intermediary Services Act, 2002
27. The Scheme may change this Privacy Statement at any time. It is you and your employees' responsibility to check our website regularly to ensure that you and they are aware of any changes. By continuing to be a member your employees agree that the latest version of the LA Health Privacy Statement, published on www.lahealth.co.za will apply to them.

28. Your employees have the right to know what personal information we hold about them. If they wish to receive this information, a 'PAIA Form to Request Access to Records' found on www.lahealth.co.za, should be completed by them, and specify the required information. We will take all reasonable steps to confirm their identity before providing details of their personal information in respect of this request. We are entitled to charge a fee for this service and will let them know what it is at the time of the request.
29. If you or your employee believe that we have used their personal information in a way that is contrary to this Privacy Statement, your employee has the right to lodge a complaint with the Information Regulator, under POPIA, but we would encourage them to first follow our internal escalation and/or disputes process to resolve the matter. We explain the escalation and/or disputes process on the website www.lahealth.co.za. The Scheme's Information Officer may also be contacted at privacy@discovery.co.za. If, having followed the process indicated above, your employee feels that we have not resolved their complaint adequately, they may contact the Information Regulator at:
- The Information Regulator (South Africa)
JD House | 27 Siemens Street | Braamfontein
PO Box 31533 | Braamfontein | 2017
Tel: **+27 (0) 10 023 5200**
POPIAComplaints@info regulator.org.za.

10. LA Health Medical Scheme terms and conditions for membership

10.1. **Terms and conditions for membership**

The terms and conditions of the Scheme record your employees' rights and responsibilities for their membership of the Scheme. They may change from time to time. You may ask us for a copy at any time.

10.2. **You may be called the principal member or main member in our future communications to you.**

10.3. **Acting for others**

You confirm you have the right to act for others

By signing this document, you confirm that you have received permission from your spouse and/or any dependant/s over 18 to act for them in any matter relating to this application.

10.4. **Giving and getting information**

You must give true, correct and complete information

To consider your application to become the main member on your membership of the Scheme, we must learn more about you. Information about you must be true, correct and complete. This includes the details you give in this application form and in future dealings with the Scheme and the Administrator.

Your legal address

We will email, SMS or post your documents to you. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

The Administrator and the Scheme may record telephone calls

The Administrator and the Scheme may record telephone conversations with you. The recordings and all information we get during the recordings will be processed and kept as required by law.

Tell the Scheme or the Administrator immediately if your information changes

You, your employer or your broker must tell the Scheme or the Administrator in writing if any of the information you gave changes between the day you sign this document and the day your membership status is changed. We need advance notice of any administrative changes such as cancellation of membership, as backdated changes may not be accepted.

When the Scheme may cancel your membership/s

The Scheme may cancel any memberships immediately:

- If you do not give the Scheme and the Administrator information that later turns out to be relevant to this application;
- If you give the Scheme and the Administrator any information that is not true, correct and complete.

10.5. **The Scheme and Administrator may get information about you from other relevant sources**

The Scheme and Administrator may (at any time and on an ongoing basis) obtain your personal information from other relevant sources, including medical practitioners, contracted service providers, LA Health brokers, credit bureaus or industry regulatory bodies ("relevant sources") and further process such information to consider your membership application, to conduct underwriting or risk assessments, to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste and/ or abuse (including by medical practitioners, contracted service providers or LA Health brokers). We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct and complete.

10.6. **You must ensure contributions are paid on time**

As the main member of the Scheme, you are responsible for ensuring that your and those persons registered as your dependants' contributions are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time. If you are paying your contributions, the reference number **LAH CONT** will be used on your bank statement to identify the debit order.

10.7. **Repaying money owed to the Scheme**

The Scheme has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you of any amount that you must pay to the Scheme.

If the benefit option you chose offers a Medical Savings Account, the Scheme makes money available in advance for you to use for medical expenses during the year. If you leave the Scheme before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to the Scheme during the specific year.

You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number **LAH CLAW** will be used. You agree that we may recover outstanding money due to the Scheme by debit order.

By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you.

Signature of main member

Date

D	D	M	M	Y	Y	Y	Y
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11. Your broker details

Did you appoint a LA Health broker? Yes No

If yes, your LA Health broker must complete the details below

Broker Code Principal

Broker house Code

Broker's contact details:

Telephone (W)

Cellphone

Signature of broker/s

BROKER STAMP

I hereby confirm that I appoint the broker indicated above to act on my behalf

Signature of main applicant

Date

**Original signature required.
The main applicant must sign and date any changes.**

12. Third Party Bank details

Please attach the relevant proof of bank account if you are providing a third party bank account for claims refund.

THIRD PARTY ACCOUNT (e.g. spouse, aunt, uncle, friend, father, son)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (account holder) ID, Passport or Driver's Licence
- A copy of the main member's ID, Passport or Driver's Licence

JOINT ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the joint account holders'

COMPANY ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of the signatories who have authority to sign on behalf of the company
- A letter of authority stating that the account can be used including the details of the signatory and stating the membership details for which the bank account will be used. The letter must be dated, signed by an authorised person on behalf of the company and it must contain the membership or policy number(s)
- A copy of the company's certificate of registration
- A copy of the main members ID, Passport or Driver's Licence

TRUST ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the trustees of the account
- A copy of the Trust's certificate of registration
- A copy of the Trust resolution, the resolution must be dated, signed by an authorised person on behalf of the Trust and it must contain the membership or policy number(s)
- A copy of the main members ID, Passport or Driver's Licence

If you are completing the request on behalf of the main member, please include proof that you have obtained the necessary authority (example, Letter of Authority or Letter of Executorship).